(HHH) walkers;

(III) water pitchers, glasses, and straws;

(JJJ) weighing scales; and

(KKK) wheelchairs.

(2) Urinary supplies. Urinary catheters and accessories shall be covered services in the Kansas medical assistance program when billed through the durable medical equipment or medical supply provider. This expense shall not be reimbursed through the per diem rate derived from the cost report.

(3) Total nutritional replacement therapy. Total nutritional replacement therapy shall be a covered service in the Kansas medical assistance program and billed through the durable medical equipment or medical supply provider. Total nutritional replacement therapy expenses shall not be reimbursed through the per diem rate derived from the cost report.

(4) Each nursing facility shall provide at no cost to residents over-the-counter drugs, supplies, and personal comfort items that meet these criteria:

(A) Are available without a prescription at a commercial pharmacy or medical supply outlet; and

(B) are provided by the facility as a reasonable accommodation for individual needs and preferences. These over-the-counter products shall be included in the nursing facility cost report. A nursing facility shall not be required to stock

all products carried by vendors in the nursing facility's community that are viewed as over-the-counter products.

(5) Occupational, physical, respiratory, speech, and other therapies. The Kansas medical assistance program cost of therapies shall be determined as follows:

(A) Compute the medicaid therapy ratio as the total number of medicaid therapy units not otherwise reimbursed to the total number of therapy units provided to all nursing facility residents during the cost report period;

(B) multiply the medicaid therapy ratio by the total reported therapy costs to determine the allowable medicaid portion of therapy costs;

(C) multiply the allowable medicaid portion of the therapy costs by the ratio of total days to medicaid resident days to determine the allowable therapy expenses for the cost report period;

(D) offset the nonallowable portion of the therapy cost in the provider adjustment column and on the related therapy expense line in the cost report; and

(E) submit a work paper with the cost report that supports the calculation of the allowable Kansas medical assistance program therapy expenses determined in accordance with paragraphs (b)(5)(A) through (C) above.

(c) Each provider of ancillary services, as defined in

K.A.R. 30-10-1a, shall bill separately for each service when the services or supplies are required. Payment for oxygen shall be reimbursed to the oxygen supplier through the agency's fiscal agent, or the fiscal agent may reimburse the nursing facility directly if an oxygen supplier is unavailable.

(d) Payment for specialized rehabilitative services or active treatment programs shall be included in the per diem reimbursement.

(e) Payment shall be limited to providers who accept, as payment in full, the amount paid in accordance with the fee structure established by the Kansas medical assistance program.

(f) Payment shall not be made for allowable, nonroutine services and items unless the provider has obtained prior authorization.

(g) Private rooms for recipients shall be provided when medically necessary or, if not medically necessary, at the discretion of the facility. If a private room is not medically necessary or is not occupied at the discretion of the facility, then a family member, guardian, conservator, or other third party may pay the difference between the usual, customary charge and the medicaid payment rate. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995; amended Jan. 1,

1997; amended Jan. 1, 1999; amended July 1, 2002; amended Aug. 15, 2003.)

30-10-17. Cost reports. (a) Historical cost data.

(1) For cost reporting purposes, each provider shall submit the "nursing facility financial and statistical report," form MS-2004,revised August 2002 and hereby adopted by reference, completed in accordance with the accompanying instructions. The MS-2004 cost report shall be submitted on diskette, using software designated by the agency for cost report periods ending on or after December 31, 1999.

(2) Each provider who has operated a facility for 12 or more months on December 31 shall file the nursing facility financial and statistical report on a calendar year basis.

(b) Projected cost data.

(1) Projected cost reports for providers.

(A) If a provider is required to submit a projected cost report under K.A.R. 30-10-18 (c) or (e), the provider's rate shall be based on a proposed budget with costs projected on a line item basis.

(B) The projected cost report for each provider who is required to file a projected cost report shall begin according to either of the following schedules:

(i) On the first day of the month in which the nursing facility was certified by the department of health and

environment if that date is on or before the 15th of the month; or

(ii) on the first day of the following month if the facility is certified by the department of health and environment between the 16th and 31st of the month.

(C) The projected cost report shall end on the last day of the 12-month period following the date specified in paragraph (b)(1)(B) above, except under either of the following:

(i) The projected cost report shall end on December 31 when that date is not more than one month before or after the end of the 12-month period.

(ii) The projected cost report shall end on the provider's normal fiscal year-end used for the internal revenue service when that date is not more than one month before or after the end of the 12-month period and the criteria in K.A.R. 30-10-18 for filing the projected cost report ending on December 31 do not apply.

(D) The projected cost report period shall cover a consecutive period of time not less than 11 months and not more than 13 months.

(E) The projected cost report shall be reviewed for reasonableness and appropriateness by the agency. The projected cost report items that are determined to be unreasonable shall be disallowed before the projected rate is established.

(2) Projected cost reports for each provider with more than one facility.

(A) Each provider who is required to file a projected cost report in accordance with this subsection and who operates more than one facility, either in state or out of state, shall allocate central office costs to each facility that is paid rates from the projected cost data. The provider shall allocate the central office cost at the end of the provider's fiscal year or the calendar year that ends during the projection period.

(B) The method of allocating central office costs to those facilities filing projected cost reports shall be consistent with the method used to allocate the costs to those facilities in the chain that are filing historical cost reports.

(c) Amended cost reports.

(1) Each provider shall submit an amended cost report revising cost report information previously submitted if an error or omission is identified that is material in amount and results in a change in the provider's rate of $.10 or more per resident day.

(2) An amended cost report shall not be allowed after 13 months have passed since the last day of the year covered by the report.

(d) Due dates of cost reports.

(1) Each calendar year cost report shall be received not

later than the close of business on the last working day of February following the year covered by the report.

(2) An historical cost report covering a projected cost report period shall be received by the agency not later than the close of business on the last working day of the second month following the close of the period covered by the report.

(3) Each cost report approved for a filing extension in accordance with subsection (e) shall be received not later than the close of business on the last working day of the month approved for the extension request.

(e) Extension of time for submitting a cost report.

(1) A one-month extension of the due date for the filing of a cost report may be granted by the agency when the cause for delay is beyond the control of the provider. Delays beyond the control of the provider that may be considered by the agency in granting an extension shall include the following:

(A) Disasters that significantly impair the routine operations of the facility or business;

(B) destruction of records as a result of a fire, flood, tornado, or another accident that is not reasonably foreseeable; and

(C) computer viruses that impair the accurate completion of cost report information.

(2) The provider shall make the request in writing. The

request shall be received by the agency on or before the due date of the cost report. Requests received after the due date shall not be accepted.

(3) A written request for a second one-month extension may be granted by the Kansas medical assistance program director if the cause for further delay is beyond the control of the provider. The request shall be received by the agency on or before the due date of the cost report, or the request shall not be approved.

(f) Penalty for late filing. Each provider filing a cost report after the due date shall be subject to the following penalties:

(1) If the complete cost report has not been received by the agency by the close of business on the due date, all further payments to the provider shall be suspended until the complete cost report has been received. A complete cost report shall include all the required documents listed in the cost report.

(2) Failure to submit the cost report within one year after the end of the cost report period shall be cause for termination from the Kansas medical assistance program.

(g) Balance sheet requirement. Each provider shall file a balance sheet prepared in accordance with cost report instructions as part of the cost report forms for each provider.

(h) Working trial balance requirement. Each provider shall

submit a working trial balance with the cost report. The working trial balance shall contain account numbers, descriptions of the accounts, the amount of each account, and the cost report expense line on which the account was reported. Revenues and expenses shall be grouped separately and totaled on the working trial balance and shall reconcile to the applicable cost report schedules. A schedule that lists all general ledger accounts grouped by cost report line number shall be attached.

(i) An allocation of expenditures between the hospital and the long-term care unit facility shall be submitted through a step-down process prescribed in the cost report instructions.

(Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997; amended Jan. 1, 1999; amended July 1, 2002; amended Dec. 31, 2002; amended, T-30-5-30-03, July 1, 2003; amended July 25, 2003.)